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BY DON MEICHENBAUM

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TREATMENT OF INDIVIDUALS WITH ANGER-CONTROL PROBLEMS AND AGGRESSIVE BEHAVIORS: A CLINICAL HANDBOOK

HOW TO USE THE ANGER-CONTROL HANDBOOK
(User-friendly Guide)

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ASSESSING AND TREATING ADULTS WITH PTSD: A CLINICAL HANDBOOK

Donald Meichenbaum, Ph. D.
600 Pages – Softcover

Section I	--	Epidemiological And Diagnostic Information
	--	Consider the nature and impact of natural, technological, and human-made disasters as evident in specific "victim populations"
	--	Critique diagnostic alternatives and "stage" theories
Section II	--	Conceptualization of PTSD
	--	Reviews alternative conceptualizations and offers a "constructive narrative perspective"
Section III	--	Assessment of PTSD
	--	Comprehensive enumeration of PTSD and related measures of comorbidity
	--	Describes a sequential gating assessment strategy
	--	Considers potential "positive" effects
	--	Includes the "best" clinical questions you can ask
Section IV	--	Cautions About Assessment
	--	Consider the controversy over so-called "false memories"
	--	How to help the helpers
Section V	--	Treatment Alternatives: A Critical Analysis
	--	Critically evaluates pharmacological, exposure, eye-movement desensitization, group interventions and other procedures
	--	Provides treatment guidelines and considers factors that influence the length of treatment
Section VI	--	Specific Treatment Procedures: Practical "How to" Guidelines
	--	"How to": Educate clients about PTSD; deal with flashbacks; intrusive ideation; guilt; anger; addictive behaviors; depression; anxiety; conduct "memory work"; and address issues of multiple and borderline personality disorders
	--	Techniques include Stress inoculation training, cognitive restructuring, problem-solving, relapse prevention and family-based interventions
Section VII	--	Post Disaster Interventions
	--	Consider who is most at "high risk"
	--	Describes and critiques Critical Incident Stress Debriefing; When can CISD make individuals "worse"?
	--	Workplace, accident, community interventions
	--	Consider the role of religion and rituals
	--	Over 1500 references

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TREATMENT CHALLENGES: FACT SHEET

(American Psychiatric Association, 1995; Institute of Medicine, 1990; McCrady & Ziedonis, 2001; Miller et al., 1995; Morgenstern et al., 2001; Najavits,& Weiss, 1994; Vaillant, 1983; Wampold et al., 1997; Zucker, 1994)

- The lifetime prevalence of drug dependence is 9.2% males and 5.9% females in the U.S., as reported in the National Comorbidity Study (Warner et al., 1995).

- Estimates of the number of children in the U.S. population having at least one parent who abuses alcohol or drugs range form 7-10 million. SUDS parents are 3 times more likely to neglect their children than control parents. Among children reported to Child Protection Services for various forms of abuse, 80% have parents with SUDS (Dunn et al., 2002).

- Individuals with addictive disorders represent an **heterogeneous population** with different etiologies and diverse courses. 80% of alcoholics never seek treatment with self-help or with treatment programs (Approximately, 10 million individuals with SUDS in U.S. do not seek treatment)

- Lifetime prevalence for alcohol abuse, alcohol dependence, or both is approximately 24% for males and 5% for females. Women comprise about 1/3 of those with substance abuse disorders.

- **Relapse rates** across chemical addictions (heroin, cocaine, nicotine, alcohol) and across various treatment modalities are **fairly uniform** and **discouraging – around 75%.** The likelihood of life-long abstinence is low.

- Among alcoholics who have been treated

  - **1/2** will be abstinent at **3** months
  - **1/3** will be abstinent at **6** months
  - **1/8** will be abstinent at **12** months
  - **1/10** will be abstinent at **18** months

- Approximately 90% of treated alcoholics have had at least one drink within 3 months of abstinence treatment. 45% - 50% will return to pretreatment drinking levels within a year.

- Overall, about **20% to 30% of alcoholic patients** evidence **long-term success** with traditional treatments.

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- 70% of those who **relapse**, will do so during the **first 3 months** after discharge. Nearly all those who relapse do so before 6 months expire. The first 90 days is the most vulnerable period for relapse across various substances of abuse (heroin, smoking, alcohol).

- Over **50%** of those who enter treatment will **drop out within the first month**. Those who drop out of treatment have worse outcomes. 70% of those who complete aftercare vs. 23% of those who dropout are abstinent after 9 months. For example, only 54% of subjects completed treatment in PROJECT MATCH and only 27% completed treatment in Morgenstern et al. (2001) major treatment community study.

- Among those seeking consultation about **20% will abstain without formal treatment** and an additional **21%** will **moderate their drinking**.

- An **intensive inpatient treatment** program is **no more effective** than less intense treatment in outpatient settings.

- Studies that have compared differing lengths of treatment for alcohol use have not found differential positive effects for longer lengths of treatment. Increasing the length and intensity of treatment may be more important in treating patients with more severe dependence and co-occurring psychiatric problems.

- Low intensity interventions that focus on assessment, feedback and recommendations to reduce heavy drinking can be effective in reducing high-risk drinking.

- There is a strong association between positive treatment outcome and aftercare attendance and treatment compliance.

- **Treatment attendance** and the **degree of therapeutic alliance** account of the largest effect and explain more variance than all other predictors combined. **There is a stronger relationship between nonspecific aspects of treatment and outcome than between active ingredients and outcome**.

- Those individuals with addictive behaviors who have **social supports for abstinence** and who are a part of social network who are involved in treatment have more favorable prognoses.

- Ample evidence demonstrates that the **treatment of additional presenting problems** leads to more positive treatment outcomes than attention to the substance use disorder alone.

- Cognitive behavioral treatment (CBT) has been found to be more effective as one component of intensive treatment programs than as a stand alone intervention. CBT places primary focus not on alcohol consumption per se, but on life areas related functionally to drinking and relapse. Research has not yet established why CBT is an effective treatment for alcohol dependence (Morgenstern & Longabaugh, 2000).

FACILITATING TREATMENT ADHERENCE

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Predicting Outcome

Brief therapies have been found to be as effective as long-term therapy for a number of psychiatric disorders (but not BPD).

The pattern of patient-therapist relationship established within the first three sessions is predictive of treatment outcome[6,7].

60% to 80% of symptom reduction in cognitive-behavior therapy of depression occurs within the first four sessions[8]

There now exist a list of empirically validated therapies (EVT)[9] and a list EVT treatment manuals[10,11].

ADDRESSING ISSUES OF TREATMENT NONADHERENCE

(See Meichenbaum & Turk, 1983; Meichenbaum & Fong, 1993)

Factors Related to Patient Noncompliance: Challenge

Understanding the Reasons for Treatment Nonadherence

Intervention Strategies

Develop a Therapeutic Alliance

Collaborative Goal-Setting

Use Motivational Interviewing

Employ Short-term Interventions